Ditesheim
COSMETIC SURGERY
Beyond the Before & After

Name:_____DOB:_____Age:_____Sex:_____

Address:_____SS#:_____

City:_____State:_____Zip:_____

Phone:_____Cell Phone:_____

E-mail:_____May we send you information by email:_____Yes _____No

Patient/ Parent's Employer:_____Work Phone:_____

For privacy purposes how do you prefer to be contacted: Phone __Home __Cell __Work ____E-Mail ____Text

Marital Status: _____Married _____Single _____Divorced _____Separated _____Widow _____Partner

About You:

- What is your hereditary background? (check all that apply)
  o Nordic o Irish o Hispanic o Mediterranean
  o English o African American o Asian o Middle Eastern
  o Native American o Scandinavian Other _____
- Natural eye color: _____
- Natural hair color: _____

Do you consider your skin (check the best option):
o Sensitive o Resilient o Unsure

- Describe your skin (check all that apply):
  o Normal o Dry o Freckled o Psoriasis o Sun-damaged o Saggy o Firm
  o Oily o Acne o Acne-scarred o Breakouts o Mature o Wrinkled o Psoriasis
  o Thin o Thick o Small pores o Large pores o Asphyxiated o Eczema o Rosacea
  o Sallow o Cysts o Milia o Melasma o Patchy dryness o Uneven/Blotchy
  o Dehydrated/Lacking moisture o Hyperpigmentation o Hypopigmentation
  o Comedones/Blackheads o T-Zone/Combination
  o Telangiectasia/Broken surface capillaries
- What are the changes you'd most like to see in your skin?

_____
_____
_____

Lifestyle:

- Are you pregnant or lactating? o No o Yes
  (**Please consult with your obstetrician.** Only the Oxygenating Trio®, Detox Gel Deep Pore Treatment or Hydrate: Therapeutic Oat Milk Mask are appropriate.)
- Do you wear contact lenses? o No o Yes
  (**Remove contacts** if eyes are sensitive or if having microdermabrasion.)
- Do you currently have a sunburned/windburned/red face? o No o Yes
  Why? _____
- Are you in the habit of going to tanning booths? o No o Yes
  (If within past 14 days, decline treatment. This practice should be discontinued due to increased risk of skin cancer and signs of aging.)
- Do you participate in vigorous aerobic activity or sports? o No o Yes
  What type? _____
- Do you smoke or use tobacco? o No o Yes
- What kind of work do you do? _____
- On average, how many hours per week do you spend outdoors? _____

Medical/Treatment History:

- Do you currently use depilatories or wax? o No o Yes
  (Discontinue use five days pre- and post-treatment.)
- Have you had a chemical peel or any type of procedure with a medical device? o No o Yes
  Within the last 14 days? o No o Yes
  What type?_____
- Do you have regular collagen, Botox® or other dermal filler injections? o No o Yes
  (Peels should precede or follow injections by two days to prevent movement of the filler or stinging at the injection site.)
- Have you recently had laser resurfacing or facial surgery? o No o Yes
  Describe _____
  When?_____
- Are you currently taking any medications, topical or otherwise? o No o Yes
  (Tretinoin/Retin-A®/Renova®/Differin®/Tazorac®/Avage®/ EpiDuo™/Ziana®)
  Which one(s)? __
  For how long? ____
  What strength? _____
  (High percentages of certain ingredients may increase sensitivity. Discontinue use five days before and after treatment. Consult your physician before discontinuing use of any prescription.)
- Are you currently using any topical retinoid prescriptions? o No o Yes
- Have you ever undergone Accutane® therapy (isotretinoin)? o No o Yes
  (**If you are currently using Accutane® therapy (isotretinoin), please consult with your dispensing physician.**)
  (If you are no longer using Accutane® therapy (isotretinoin) it is OK to apply ONE layer of Ultra Peel® I, Sensi Peel,® Ultra Peel® II, Esthetique Peel, Oxy Trio,® Hydrate: Therapeutic Oat Milk Mask or Revitalize: Therapeutic Papaya Mask.)
- Do you develop cold sores/fever blisters? o No o Yes
  Last breakout? _____
- Are you allergic/sensitive to (check all that apply) o No o Yes
  o milk o apples o citrus o grapes o aloe vera
  o aspirin o perfumes o latex o hydroquinone o mushrooms?
  If any other allergies, what? _____
- Have you ever used any other products that caused a bad reaction? o No o Yes
  Describe _____

How were you referred to us:_____

Emergency Contact:_____Relationship:_____

Phone Number:_____

Patient Signature:_____Date:_____

Clinician Signature:_____Date:_____